HEALTH HISTORY

Name ______ Date of birth ______ Date ______

Address ______ City ______ State ______ Zip Code ______

Phone ______ E-mail ______

Occupation ______ Age ______ Height ______ Sex ____ Number of Children ______

Marital Status: ☐ Single ☐ Partner ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er)

Are you recovering from a cold or flu? ______ Are you pregnant? ______

Reason for office visit: Date began:

______

______

______

Date of last physical exam ______ Practitioner name and phone number ______

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis):

______

Outcome ______

What types of therapy have you tried for this problem(s):

☐ diet modification ☐ fasting ☐ vitamins/minerals ☐ herbs ☐ homeopathy ☐ chiropractic ☐ acupuncture ☐ conventional drugs

☐ other ______

List current health problems for which you are being treated: ______

______

______

Current medications (prescription or over-the-counter): ______

______

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
______	______	______
______	______	______

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): ______

Do you consider yourself: ☐ underweight ☐ overweight ☐ just right Your weight today ______

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? ______

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, farmer, miner)?

______

☐ Corrective lenses ☐ Dentures ☐ Hearing aid ☐ Medical devices/prosthetics/implants, describe: ______

Recent changes in your ability to: ☐ see ☐ hear ☐ taste ☐ smell ☐ feel hot/cold sensations

☐ move around (sit upright, stand, walk, run, pick up things, swing your arms freely, turn your head, wiggle fingers)

Strong like for any of the following flavors: ☐ sour ☐ bitter ☐ sweet ☐ rich/fatty ☐ spicy/pungent ☐ salty

Strong dislike for any one of the following flavors: ☐ sour ☐ bitter ☐ sweet ☐ rich/fatty ☐ spicy/pungent ☐ salty

Do you: ☐ Prefer warmth (i.e., food, drinks, weather, etc.) ☐ Prefer cold (i.e., food, drinks, weather, etc.) ☐ No preference

Is your sleep disturbed at the same time each night? ______ If yes, what time? ______

Time of day you feel the worst or your symptoms are aggravated:

☐ 7 a.m. - 9 a.m. ☐ 9 a.m. - 11 a.m. ☐ 11 a.m. - 1 p.m.
☐ 1 p.m. - 3 p.m. ☐ 3 p.m. - 5 p.m. ☐ 5 p.m. - 7 p.m.
☐ 7 p.m. - 9 p.m. ☐ 9 p.m. - 11 p.m. ☐ 11 p.m. - 1 a.m.
☐ 1 a.m. - 3 a.m. ☐ 3 a.m. - 5 a.m. ☐ 5 a.m. - 7 a.m.

Time of day you feel the most energy or the least symptoms are aggravated

☐ 7 a.m. - 9 a.m. ☐ 9 a.m. - 11 a.m. ☐ 11 a.m. - 1 p.m.
☐ 1 p.m. - 3 p.m. ☐ 3 p.m. - 5 p.m. ☐ 5 p.m. - 7 p.m.
☐ 7 p.m. - 9 p.m. ☐ 9 p.m. - 11 p.m. ☐ 11 p.m. - 1 a.m.
☐ 1 a.m. - 3 a.m. ☐ 3 a.m. - 5 a.m. ☐ 5 a.m. - 7 a.m.

Do you experience any of these general symptoms EVERY DAY?

☐ Debilitating fatigue ☐ Shortness of breath ☐ Insomnia ☐ Constipation ☐ Chronic pain/inflammation
☐ Depression ☐ Panic attacks ☐ Nausea ☐ Fecal incontinence ☐ Bleeding
☐ Disinterest in sex ☐ Headaches ☐ Vomiting ☐ Urinary incontinence ☐ Discharge
☐ Disinterest in eating ☐ Dizziness ☐ Diarrhea ☐ Low grade fever ☐ Itching/rash

Medical History
- ☐ Arthritis
- ☐ Allergies/hay fever
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Autoimmune disease
- ☐ Blood pressure problems
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chronic fatigue syndrome
- ☐ Carpal tunnel syndrome
- ☐ Cholesterol, elevated
- ☐ Circulatory problems
- ☐ Colitis
- ☐ Dental problems
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticular disease
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Eyes, ears, nose, throat problems
- ☐ Environmental sensitivities
- ☐ Fibromyalgia
- ☐ Food intolerance
- ☐ Gastroesophageal reflux disease
- ☐ Genetic disorder
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart disease
- ☐ Infection, chronic
- ☐ Inflammatory bowel disease
- ☐ Irritable bowel syndrome
- ☐ Kidney or bladder disease
- ☐ Learning disabilities
- ☐ Liver or gallbladder disease (stones)
- ☐ Mental illness
- ☐ Mental retardation
- ☐ Migraine headaches
- ☐ Neurological problems (Parkinson's, paralysis)
- ☐ Sinus problems
- ☐ Stroke
- ☐ Thyroid trouble
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Sexually transmitted disease
- ☐ Seasonal affective disorder
- ☐ Skin problems
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Urinary tract infection
- ☐ Varicose veins

Other ______________________

____

Medical (Men)
- ☐ Benign prostatic hyperplasia (BPH)
- ☐ Prostate cancer
- ☐ Decreased sex drive
- ☐ Infertility
- ☐ Sexually transmitted disease

Other ______________________

____

Medical (Women)
- ☐ Menstrual irregularities
- ☐ Endometriosis
- ☐ Infertility
- ☐ Fibrocystic breasts
- ☐ Fibroids/ovarian cysts
- ☐ Premenstrual syndrome (PMS)
- ☐ Breast cancer
- ☐ Pelvic inflammatory disease
- ☐ Vaginal infections
- ☐ Decreased sex drive
- ☐ Sexually transmitted disease

Other ______________________

Age of first period ______

Date of last gynecological exam ______

Mammogram ☐ + ☐ –

PAP ☐ + ☐ –

Form of birth control ____________

# of children ____________

# of pregnancies ____________

☐ C-section ____________

☐ Surgical menopause

☐ Menopause

Date - last menstrual cycle ________

Length of cycle ____________ days

Interval of time between cycles

____________ days

Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty)

Family Health History (Parents and Siblings)
- ☐ Arthritis
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Genetic disorder
- ☐ Glaucoma
- ☐ Heart disease
- ☐ Infertility
- ☐ Learning disabilities
- ☐ Mental illness
- ☐ Mental retardation
- ☐ Migraine headaches
- ☐ Neurological disorders (Parkinson's, paralysis)
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Suicide

Other ______________________

Health Habits
☐ Tobacco:

Cigarettes: #/day ____________

Cigars: #/day ____________

☐ Alcohol:

Wine: #glasses/d or wk ____________

Liquor: #ounces/d or wk ____________

Beer: #glasses/d or wk ____________

☐ Caffeine:

Coffee: #6 oz cups/d ____________

Tea: #6 oz cups/d ____________

Soda w/caffeine: #cans/d ____________

Other sources ____________

☐ Water: #glasses/d ____________

Exercise
- ☐ 5-7 days per week
- ☐ 3-4 days per week
- ☐ 1-2 days per week
- ☐ 45 minutes or more duration per workout
- ☐ 30-45 minutes duration per workout
- ☐ Less than 30 minutes
- ☐ Walk
- ☐ Run, jog, jump rope
- ☐ Weight lift
- ☐ Swim
- ☐ Box
- ☐ Yoga

Nutrition & Diet
- ☐ Mixed food diet (animal and vegetable sources)
- ☐ Vegetarian
- ☐ Vegan
- ☐ Salt restriction
- ☐ Fat restriction
- ☐ Starch/carbohydrate restriction
- ☐ The Zone Diet
- ☐ Total calorie restriction

Specific food restrictions:

☐ dairy ☐ wheat ☐ eggs

☐ soy ☐ corn ☐ all gluten

Other ____________

Food Frequency
Number of servings per day:

Fruits (citrus, melons, etc.) ________

Dark green or deep yellow/orange vegetables ________

Grains (unprocessed) ________

Beans, peas, legumes ________

Dairy, eggs ________

Meat, poultry, fish ________

Eating Habits
- ☐ Skip breakfast
- ☐ Two meals/day
- ☐ One meal/day
- ☐ Graze (small frequent meals)
- ☐ Food rotation
- ☐ Eat constantly whether hungry or not
- ☐ Generally eat on the run
- ☐ Add salt to food

Current Supplements
- ☐ Multivitamin/mineral
- ☐ Vitamin C
- ☐ Vitamin E
- ☐ EPA/DHA
- ☐ Evening Primrose/GLA
- ☐ Calcium, source ____________
- ☐ Magnesium
- ☐ Zinc
- ☐ Minerals, describe ____________
- ☐ Friendly flora (acidophilus)
- ☐ Digestive enzymes
- ☐ Amino acids
- ☐ CoQ10
- ☐ Antioxidants (e.g., lutein, resveratrol, etc.)
- ☐ Herbs - teas
- ☐ Herbs - extracts
- ☐ Chinese herbs
- ☐ Ayurvedic herbs
- ☐ Homeopathy
- ☐ Bach flowers
- ☐ Protein shakes
- ☐ Superfoods (e.g., bee pollen, phytonutrient blends)
- ☐ Liquid meals

Other ______________________

Would you like to:
- ☐ Have more energy
- ☐ Be stronger
- ☐ Have more endurance
- ☐ Increase your sex drive
- ☐ Be thinner
- ☐ Be more muscular
- ☐ Improve your complexion
- ☐ Have stronger nails
- ☐ Have healthier hair
- ☐ Be less moody
- ☐ Be less depressed
- ☐ Be less indecisive
- ☐ Feel more motivated
- ☐ Be more organized
- ☐ Think more clearly and be more focused
- ☐ Improve memory
- ☐ Do better on tests in school
- ☐ Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- ☐ Stop using laxatives or stool softeners
- ☐ Be free of pain
- ☐ Sleep better
- ☐ Have agreeable breath
- ☐ Have agreeable body odor
- ☐ Have stronger teeth
- ☐ Get less colds and flus
- ☐ Get rid of your allergies
- ☐ Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)

Medical Symptoms Questionnaire

Patient Name ______________________ Date ______________ Week ________

Rate each of the following symptoms based upon your typical health profile for:
Past 30 days *Past 48 hours*

Point Scale

0 - *Never* or *almost never* have the symptom
1 - *Occasionally* have it, effect is *not severe*
2 - *Ocasionally* have it, effect is *severe*
3 - *Frequently* have it, effect is *not severe*
4 - *Frequently* have it, effect is *severe*

HEAD

_______ Headaches
_______ Faintness
_______ Dizziness
_______ Insomnia

Total _______

EYES

_______ Watery or itchy eyes
_______ Swollen, reddened or sticky eyelids
_______ Bags or dark circles under eyes
_______ Blurred or tunnel vision
(does not include near- or far-sightedness)

Total _______

EARS

_______ Itchy ears
_______ Earaches, ear infections
_______ Drainage from ear
_______ Ringing in ears, hearing loss

Total _______

NOSE

_______ Stuffy nose
_______ Sinus problems
_______ Hay fever
_______ Sneezing attacks
_______ Excessive mucus formation

Total _______

MOUTH/THROAT

_______ Chronic coughing
_______ Gagging, frequent need to clear throat
_______ Sore throat, hoarseness, loss of voice
_______ Swollen or discolored tongue, gums, lips
_______ Canker sores

Total _______

SKIN

_______ Acne
_______ Hives, rashes, dry skin
_______ Hair loss
_______ Flushing, hot flashes
_______ Excessive sweating

Total _______

HEART

_______ Irregular or skipped heartbeat
_______ Rapid or pounding heartbeat
_______ Chest pain

Total _______

LUNGS	_______	Chest congestion	
	_______	Asthma, bronchitis	
	_______	Shortness of breath	
	_______	Difficulty breathing	Total _______
DIGESTIVE TRACT	_______	Nausea, vomiting	
	_______	Diarrhea	
	_______	Constipation	
	_______	Bloated feeling	
	_______	Belching, passing gas	
	_______	Heartburn	
	_______	Intestinal/stomach pain	Total _______
JOINTS/MUSCLE	_______	Pain or aches in joints	
	_______	Arthritis	
	_______	Stiffness or limitation of movement	
	_______	Pain or aches in muscles	
	_______	Feeling of weakness or tiredness	Total _______
WEIGHT	_______	Binge eating/drinking	
	_______	Craving certain foods	
	_______	Excessive weight	
	_______	Compulsive eating	
	_______	Water retention	
	_______	Underweight	Total _______
ENERGY/ACTIVITY	_______	Fatigue, sluggishness	
	_______	Apathy, lethargy	
	_______	Hyperactivity	
	_______	Restlessness	Total _______
MIND	_______	Poor memory	
	_______	Confusion, poor comprehension	
	_______	Poor concentration	
	_______	Poor physical coordination	
	_______	Difficulty in making decisions	
	_______	Stuttering or stammering	
	_______	Slurred speech	
	_______	Learning disabilities	Total _______
EMOTIONS	_______	Mood swings	
	_______	Anxiety, fear, nervousness	
	_______	Anger, irritability, aggressiveness	
	_______	Depression	Total _______
OTHER	_______	Frequent illness	
	_______	Frequent or urgent urination	
	_______	Genital itch or discharge	
			Total _______
GRAND TOTAL			*TOTAL* _______

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MEDICAL ASSESSMENT

Date: __________ Name:_______________________________________ Date of Birth: _____________

Address: ____ Telephone Number: _______________

Pharmacy: ____ Telephone Number: _______________

Pharmacy Address:____

Drug Allergies (Name of Medication(s):____

____

Reaction: ____

Medications prescribed by other clinics and/or physicians:

Date	Medication	Dosage	Directions	Refills	Physician

Over the counter remedies: __ analgesics __ antihistamines __ decongestants __ diuretics
___ other: ________________________

Caffeine: __ coffee __ chocolate __ soda __ tea How much? _________

Types of alcohol/drugs used in the past: ____

____

Currently: ____

Height: _________ Weight: _________ Blood Pressure: __________ Pulse: __________

Health __ Poor __ Fair __ Good __ Very Good

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Have you ever been treated for any of the following:

	Yes	No		Yes	No
Alcoholism			High Blood Pressure		
Allergies			Injuries		
Bleeding (excessive)			Kidney Disease		
Cancer/Tumors			Liver Disease (hepatitis/jaundice)		
Diabetes			Pancreatitis		
Drug Abuse/Addiction			Pregnancy How many? ___		
Epilepsy/Seizures			Psychiatric Problems		
Gastritis			Surgery		
Glaucoma			Thyroid Disease		
Headaches			Urinary/Prostate		
Head Injury			Weight Gain		
Heart Disease			Weight Loss		

Other (please specify):____

What medical problems are you currently being treated for?

____

____

How many doctor visits in the last six months? For what?

____

____

Names of doctors and their specialties

____

____

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Hospitalizations:

Date	Hospital	Reason

Important medical problems in family members:

___

___

___

Smoking tobacco products, drinking alcohol, and using drugs other than prescribed by your physician can interfere with certain medicines and treatments. Therefore, it is important that we ask you some questions about your alcohol, tobacco, and drug use. <u>Your answers will remain confidential, so please be honest.</u> If we find you are using more than you or we feel is good for you, we have services that can help you take better care of yourself. In each case, circle the answer that best describes your situation.

Smoking	Yes	No
1. Do you usually smoke your first cigarette of the day within 30 minutes of waking up?		
2. Do you find it hard not to smoke in places where it's not allowed, such as the library, theater or doctor's office?		
3. Do you smoke 10 or more cigarettes per day?		
4. Do you smoke 20 or more cigarettes per day?		
5. Do you smoke more in the morning than the rest of the day?		
6. Do you smoke even when you are so ill that you are in bed most of the day?		
Total		

Alcohol	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3X a week	4 or more times a week	
How many drinks containing alcohol do you have on a typical day you are drinking	1 or 2	3 to 4	5 or 6	7 or 8	10 or more	
How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

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Alcohol (continued)	0	1	2	3	4	
How often drink the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the past year have you failed to do what was expected of you because you were drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the past year have you needed a drink first thing in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the past year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during ht past year have you been unable to remember what happened the nifht before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or someone else been injured because of your drinking?	No		Yes, but not in the past year		Daily or almost daily	
Has a relative, friend, doctor, or other health care worker been concerned about your drinking and suggest that you cut down?	No		Yes, but not in the past year		Yes, during the past year	
					Total	

Drug Use	Yes	No
Do you use any drugs other than tobacco or those prescribed by a physician?		
Have you ever felt you should cut down on your drug use?		
Have people ever annoyed you by criticizing your drug use?		
Have you ever felt bad or guilty about your drug use?		
Have you ever used a drug first thing in the morning to steady nerves or to get rid of a hangover?		
Has a physician or other professional ever told you to cut down or quit use of drugs?		
Has your drug use caused family problems?		
When using drugs, have you ever had a memory loss or blackout?		

Which drugs do you use? (circle as many as apply) marijuana cocaine/crack heroin pain pills downers/sedatives ecstasy/club drugs amphetamine/speed/crank

Would you be interested in discussing your or a loved one’s use of alcohol, tobacco or other drugs? Y N

No Intervention: ( ) Advise ____________________________________ Referral ________________________

Materials Given ( ) Patient’s response ____________________________ Followup ______________________

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PATIENT AUTHORIZATION

I have received, read and agree to the terms in General Information, viewable at http://mlfassmd.com/information/general-information/ and effective July, 2013.

Signature **Name (Printed)** **Date**

I have received, the Notice of Privacy Practices viewable at http://mlfassmd.com/information/notice-of-privacy-practices/ and effective July, 2013.

Signature

I authorize the release of any medical or other information necessary to process my insurance claim.

Signature

I authorize payment of medical benefits by my insurance carrier directly to my provider for services that she bills to the carrier.

Signature

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RELEASE OF INFORMATION

I hereby authorize Dr. Fass to receive and/or disclose protected health information re: (patient name) ____ DOB: __________________.

From/To: (Name & Address of Recipient)

____

for the purpose of coordination of care, diagnostic assessment, follow-up, referral or other

____

I understand that:

1. THIS AUTHORIZATION IS VOLUNTARY & I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY HEALTH CARE OR THE PAYMENT FOR MY HEALTH CARE.
2. I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state & federal law. See 45 CFR/164.524).
3. I may revoke this authorization at any time by notifying Dr. Fass in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon.
4. If the person or organization authorized to receive the information is not a health plan, health care clearing house or health care provider, Federal Privacy Regulations may no longer protect the released information.
5. If I am authorizing the release of drug or alcohol information, the recipient is prohibited from re-disclosing any drug and alcohol information without my authorization unless permitted to do so under federal or state law.

Type of Information to be Disclosed:

___ Laboratory Results
___ Verbal/Written Communication
___ Medication Flow Sheets
___ History, Physical Exam or Psychiatric Evaluation
___ Emergency & Urgent Care Records
___ Other: ____________________________________

In addition, I authorize that this will include health information relating to (check if applicable):

___ Genetic Testing ___ Drug/Alcohol Abuse

Please describe kind and amount of drug/alcohol information to be disclosed:

___ Routine Screening Questions ___ Other: ____________________________________

Expiration: This authorization will be valid ongoing throughout treatment and/or until a specific written withdrawal of permission is submitted to Dr. Fass.

_______________________________ _______________________________
(Patient Signature) (Parent or Guardian Signature)

_______________________________ _______________________________
(Witness: Signature) (Date)

Patient Assessment Form – Mental Health

Name: ____ **Date:** __________________

Attention Deficit/Hyperactivity Disorder – 314.00			
		No	**Yes**
1.	Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or during other activities (eg. overlooks or misses details, work is inaccurate).	0	1
2.	Often has difficulty sustaining attention in tasks or play activities (eg. has difficulty remaining focused during lectures, conversations, or lengthy reading).	0	1
3.	Often does not seem to listen when spoken to directly (eg. mind seems elsewhere, even in the absence of any obvious distraction).	0	1
4.	Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (eg. starts tasks but quickly loses focus and is easily sidetracked).	0	1
5.	Often has difficulty organizing tasks and activities (eg. difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy disorganized work; has poor time management; fails to meet deadlines.	0	1
6.	Often avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort (eg. schoolwork, homework; for older adolescents and adults, preparing reports completing forms, reviewing lengthy papers).	0	1
7.	Often loses things necessary for tasks or activities (eg. school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, cell phones).	0	1
8.	Is often easily distracted by extraneous stimuli (for older adolescents and adults, may include unrelated thoughts).	0	1
9.	Is often forgetful in daily activities (eg. doing chores, running errands, for older adolescents and adults, returning calls, paying bills, keeping appointments).	0	1
	(Attention Deficit/Hyperactivity Disorder) -Total		

Hyperactivity and impulsivity – 314.01			
		No	**Yes**
1.	Often fidgets with or taps hands or feet or squirms in seat.	0	1
2.	Often leaves seat in situations when remaining seated is expected (eg. leaves his or her place in the classroom, in the office or other workplace, or in other situations that require remaining in place).	0	1
3.	Often runs about or climbs in situations where it is inappropriate (Note: in adolescents or adults, may be limited to feeling restless).	0	1
4.	Often unable to play or engage in leisure activities quietly.	0	1
5.	Is often "on the go," acting as if "driven by a motor" (eg. is unable to be or is uncomfortable being still for extended time, as in restaurants, meetings, may be experienced by others as being restless or difficult to keep up with.	0	1
6.	Often talks excessively.	0	1
7.	Often blurts out an answer before a question has been completed (eg. completes people's sentences; cannot wait for turn in conversations).	0	1
8.	Often has difficulty waiting his or her turn (eg. while waiting in line).	0	1
9.	Often interrupts or intrudes on others (eg. butts into conversations, games, or activities; may start using other people's things without asking or receiving permiss-ion; for adolescents and adults, may intrude into or take over what others are doing	0	1
	(Hyperactivity and impulsivity) - Total		

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Patient Assessment Form – Mental Health

Name: ______________________________ **Date:** ________________

Brief Psychotic Disorder - 298.8			
		No	**Yes**
1.	Delusions	0	1
2.	Hallucinations	0	1
3.	Disorganized speech (eg. frequent derailment or incoherence).	0	1
4.	Grossly disorganized or catatonic behavior	0	1
	Brief Psychotic Disorder - Total		

Manic Episode – (Bipolar I - 296.4X)			
		No	**Yes**
1.	Inflated self-esteem or grandiosity.	0	1
2.	Decreased need for sleep (eg. feels rested after only 3 hours of sleep).	0	1
3.	More talkative than usual or pressure to keep talking.	0	1
4.	Flight of ideas or subjective experience that thoughts are racing.	0	1
5.	Distractibility (eg. attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.	0	1
6.	Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (eg. purposeless non-goal-directed activity).	0	1
7.	Excessive involvement in activities that have a high potential for painful consequences (eg. engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).	0	1
	(Manic Episode) - Total		

Major Depressive Episode – 296.2X or 296.3X (Bipolar I - 296.4X)			
		No	**Yes**
1.	Depressed mood most of the day, nearly every day, as indicated by either subjective report (eg. feels sad, empty, or hopeless) or observation made by others (eg. appears fearful) (**Note:** In children and adolescents, can be irritable mood	0	1
2.	Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).	0	1
3.	Significant weight loss when not dieting or weight gain (eg. a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day (**Note:** In children, consider failure to make expected weight gain.)	0	1
4.	Insomnia or hypersomnia nearly every day.	0	1
5.	Psychomotor agitation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).	0	1
		No	**Yes**

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Name: ______________________________ **Date:** ______________

6.	Fatigue or loss of energy nearly every day.	0	1
7.	Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).	0	1
8.	Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).	0	1
9.	Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideations without a specific plan, or a suicide attempt or a specific plan for committing suicide.	0	1
	(Major Depressive Episode) - Total		

Persistent Depressive Disorder (Dysthymia) - 300.4			
		No	**Yes**
1.	Depressed mood for most of the day, for more days than not, as indicated by either subjective account or observation by others, for at least 2 years.	0	1
	(Persistent Depressive Disorder) - Total		

Separation Anxiety Disorder - 309.21			
		No	**Yes**
1.	Recurrent excessive distress when anticipating or experiencing separation from home or from major attachment figures.	0	1
2.	Persistent and excessive worry about losing major attachment figures or about possible harm to them, such as illness, injury, disasters, or death.	0	1
3.	Persistent and excessive worry about experiencing an unexpected event (eg. getting lost, being kidnapped, having an accident, becoming ill) that causes separation from a major attachment figure.	0	1
4.	Persistent reluctance or refusal to go out, away from home, to school, to work, or elsewhere because of fear of separation.	0	1
5.	Persistent and excessive fear of or reluctance about being alone or without major attachment figures at home or in other settings.	0	1
6.	Persistent reluctance or refusal to sleep away from home or to go to sleep without being near a major attachment figure.	0	1
7.	Repeated nightmares involving the theme of separation.	0	1
8.	Repeated complaints of physical symptoms (eg. headaches, stomachaches, nausea, vomiting) when separation from major attachment figures occurs or is anticipated.	0	1
	(Separation Anxiety Disorder) - Total		

Panic Disorder - 300.01

Patient Assessment Form – Mental Health

Name: ____ **Date:** ____________________

		No	Yes
1.	Palpitations, pounding heart, or accelerated heart rate.	0	1
2.	Sweating.	0	1
3.	Trembling or shaking.	0	1
4.	Sensations of shortness of breath or smothering.	0	1
5.	Feeling of choking.	0	1
6.	Chest pain or discomfort.	0	1
7.	Nausea or abdominal distress.	0	1
8.	Feeling dizzy, unsteady, light-headed, or faint.	0	1
9.	Chills or heat sensations.	0	1
10.	Paresthesia (numbness or tingling sensations).	0	1
11.	Derealization (feelings of unreality) or depersonalization (being detached from oneself).	0	1
12.	Fear of losing control or "going crazy."	0	1
13.	Fear of dying.	0	1
	(Panic Disorder) - Total		

Agoraphobia - 300.22			
	Fears of:	**No**	**Yes**
1.	Using public transportation (eg. automobiles, buses, trains, ships, planes).	0	1
2.	Being in open spaces (eg. parking lots, marketplaces, bridges).	0	1
3.	Being in enclosed places (eg. shops, theatres, cinemas).	0	1
4.	Standing in line or being in a crowd.	0	1
5.	Being outside of the home alone.	0	1
	(Agoraphobia) - Total		

Generalized Anxiety Disorder - 300.02			
		No	**Yes**
1.	Restlessness or feeling keyed up or on edge.	0	1
2.	Being easily fatigued.	0	1
3.	Difficulty concentrating or mind going blank.	0	1
4.	Irritability.	0	1
5.	Muscle tension.	0	1
6.	Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).	0	1
	(Generalized Anxiety Disorder) – Total		

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Social Anxiety Disorder 300.23			
		No	**Yes**

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Patient Assessment Form – Mental Health

Name: ______________________________ **Date:** ______________

1.	Marked fear or anxiety about one or more social situations in which you are exposed to possible scrutiny by others.	0	1
2.	The individual fears that he or she will act in a way or show anxiety symptoms that will be negatively evaluated.	0	1
3.	The social situation almost always provokes fear or anxiety.	0	1
4.	The social situations are avoided or endured with intense fear or anxiety.	0	1
5.	The fear or anxiety is out of proportion to the actual threat posed by the social situation and to the socio-cultural context.	0	1
6.	The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.	0	1
7.	The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.	0	1
8.	The fear, anxiety, or avoidance is not attributable to the physiological effects of a substance or another medical condition.	0	1
9.	The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder.	0	1
10.	If another medical condition is present, the fear, anxiety or avoidance is clearly unrelated or is excessive.	0	1
	(Social Anxiety Disorder) – Total		

Obsessive-Compulsive Disorder - 300.3			
	Obsessions	**No**	**Yes**
1.	Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals causes marked anxiety or distress.	0	1
2.	The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (ie. by performing a compulsion).	0	1
	Compulsions	**No**	**Yes**
1.	Repetitive behaviors or mental acts that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.	0	1
2.	The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designated to neutralize or prevent, or are clearly excessive.	0	1
	(Obsessive-Compulsive Disorder) - Total		

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Posttraumatic Stress Disorder - 309.81			
	Exposure	**No**	**Yes**
1.	Directly experiencing the traumatic event(s).	0	1

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Name: ____ **Date:** ____________________

2.	Witnessing, in person, the event(s) as it occurred to others.	0	1
3.	Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.	0	1
4.	Experiencing repeated or extreme exposure to aversive details of the traumatic event(s). (eg. first responders collecting human remains; police officers repeatedly exposed to details of child abuse).	0	1
	Intrusion	**No**	**Yes**
5.	Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). **Note:** In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.	0	1
6.	Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s). **Note:** In children, there may be frightening dreams without recognizable content.	0	1
7.	Dissociative reactions (eg. flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings. **Note:** In children, trauma-specific reenactment may occur in play.	0	1
8.	Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).	0	1
9.	Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).	0	1
	Avoidance	**No**	**Yes**
10.	Avoidance of, or efforts to avoid distressing memories, thoughts, or feelings about, or closely associated with the traumatic event(s).	0	1
11.	Avoidance of, or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about, or closely associated with the traumatic event(s).	0	1
	Cognition	**No**	**Yes**
12.	Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).	0	1
13.	Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (eg. "I am bad", "No one can be trusted", "The world is completely dangerous", "My whole nervous system is permanently ruined").	0	1
14.	Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.	0	1
15.	Persistent negative emotional state (eg. fear, horror, anger, guilt, or shame).	0	1
16.	Markedly diminished interest or participation in significant activities.	0	1
	Cognition (cont)	**No**	**Yes**
17.	Feelings of detachment or estrangement from others.	0	1
18.	Persistent inability to experience positive emotions (eg. inability to experience		

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	happiness, satisfaction, or loving feelings).	0	1
	Arousal and Reactivity	**No**	**Yes**
19.	Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.	0	1
20.	Reckless or self-destructive behavior.	0	1
21.	Hypervigilance.	0	1
22.	Exaggerated startle response.	0	1
23.	Problems with concentration.	0	1
24.	Sleep disturbances (eg. difficulty falling or staying asleep, or restless sleep).	0	1
	(Posttraumatic Stress Disorder) - Total		

Anorexia Nervosa – 307.1			
		No	**Yes**
1.	Restriction of energy intake relative to requirements, leading to a significant low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal, or, for children and adolescents, less than the minimally expected	0	1
2.	Intense fear of gaining weight or becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.	0	1
3.	Disturbance in the way in which one's body weight or shape is; experienced undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.	0	1
	(Anorexia Nervosa) - Total		

Bulimia Nervosa - 307.51			
		No	**Yes**
1.	Eating, in a discrete period of time (eg. within a 2-hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances.	0	1
2.	A sense of lack of control over eating during the episode (eg. a feeling that one cannot stop eating or control what or how much on is eating).	0	1
3.	Recurrent inappropriate compensatory behaviors in order to prevent weight gain, such as self-induced vomiting, misuse of laxatives, diuretics, or other medications, fasting or excessive exercise.	0	1
4.	The binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for 3 months.	0	1
Bulimia Nervosa - 307.51 (cont)			
		No	**Yes**
5.	Self-evaluation is unduly influenced by body shape and weight.	0	1
6.	The disturbance does not occur exclusively during episodes of anorexia	0	1

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	nervosa.		
	(Bulimia Nervosa) - Total		

Binge-Eating Disorder - 307.51			
		No	**Yes**
1.	Eating in a discrete period of time (eg. within any 2-hour period), an amount of food that is definitely larger than what most people would eat in a similar period of time under similar circumstances.	0	1
2.	A sense of lack of control over eating during the episode (eg. a feeling that one cannot stop eating or control what or how much one is eating).	0	1
3.	Eating much more rapidly than normal.	0	1
4.	Eating until feeling uncomfortably full.	0	1
5.	Eating large amounts of food when not feeling physically hungry.	0	1
6.	Eating alone because of feeling embarrassed by how much one is eating.	0	1
7.	Feeling disgusted with oneself, depressed, or very guilty afterward.	0	1
	(Binge-Eating Disorder) - Total		
Insomnia Disorder - 780.52			
		No	**Yes**
1.	A predominant complaint of dissatisfaction with sleep quantity or quality, associated with one (or more) of the following symptoms (circle if applicable): ■ difficulty initiating sleep ■ difficulty maintaining sleep, characterized by frequent awakenings or problems returning to sleep after awakenings. ■ early morning awakening with inability to return to sleep.	0	1
2.	A sleep disturbance causes clinical significant distress or impairment in social, occupational, educational, academic, behavioral, or other important areas of functioning.	0	1
3.	Sleep difficulty occurs at least 3 times per week.	0	1
4.	Sleep difficulty is present for at least 3 months.	0	1
5.	Sleep difficulty occurs despite adequate opportunity for sleep.	0	1
6.	Insomnia is not better explained by and does not occur exclusively during the course of another sleep-awake disorder.	0	1
7.	Insomnia is not attributable to the physiological effects of a substance.	0	1
8.	Coexisting mental disorders and medical conditions do not adequately explain the predominant complaint of insomnia.	0	1
	(Insomnia Disorder) - Total		
Hyper somnolence Disorder - 780.54			
		No	**Yes**
1.	Recurrent periods of sleep or lapses into sleep within the same day.	0	1
2.	A prolonged main sleep episode of more than 9 hours per day that is non-		

Name: ______________________________ **Date:** ____________________

	restorative (eg. unrefreshing).	0	1
3.	Difficulty being fully awake after abrupt awakening.	0	1
	(Hyper somnolence Disorder) - Total		

Restless Legs Syndrome - 333.94			
		No	**Yes**
1.	The urge to move the legs begins or worsens during periods of rest or inactivity.	0	1
2.	The urge to move the legs is partially or totally relieved by movement.	0	1
3.	The urge to move the legs is worse in the evening or at night than during the day or occurs only in the evening or at night.	0	1
	(Restless Legs Syndrome) - Total		

Oppositional Defiant Disorder - 313.81			
	Angry/Irritable Mood	**No**	**Yes**
1.	Often loses temper.	0	1
2.	Is often touchy or easily annoyed.	0	1
3.	Is often angry or resentful.	0	1
	Argumentative/Defiant Behavior	0	1
4.	Often argues with authority figures or, for children and adolescents, with adults.	0	1
5.	Often actively defies or refuses to comply with requests from authority figures or with rules.	0	1
6.	Often deliberately annoys others.	0	1
7.	Often blames others for his or her mistakes or misbehavior.	0	1
	Vindictiveness		
8.	Has been spiteful or vindictive at least twice within the past 6 months.	0	1
	(Oppositional Defiant Disorder) - Total		

Intermittent Explosive Disorder - 312.34			
		No	**Yes**
1.	Verbal aggression (eg. temper tantrums, tirades, verbal arguments or fights) or physical aggression toward property, animals or other individuals, occurring twice weekly, on average, for a period of 3 months. The physical aggression does not result in damage or destruction of property and does not result in physical injury to animals or other individuals.	0	1
2.	Three behavioral outbursts involving damage or destruction of property and/or physical assault involving physical injury against animals or other individuals occurring within a 12-month period.	0	1
	(Intermittent Explosive Disorder) - Total		

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Patient Assessment Form – Mental Health

Name: ____ **Date:** __________________

Alcohol Use Disorder – 305.0 or 303.9			
		No	**Yes**
1.	Alcohol is taken in larger amounts or over a longer period than was intended.	0	1
2.	There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.	0	1
3.	A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.	0	1
4.	Craving, or a strong desire or urge to use alcohol.	0	1
5.	Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home.	0	1
6.	Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.	0	1
7.	Important social, occupational, or recreational activities are given up or reduced because of alcohol use.	0	1
8.	Recurrent alcohol use in situation in which it is physically hazardous.	0	1
9.	Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.	0	1
10.	*Tolerance, as defined by either of the following:* A need for markedly increased amounts of alcohol to achieve intoxication or desired effect. Or a markedly diminished effect with continued use of the same amount of alcohol.	0	1
11.	*Withdrawal, as manifested by either of the following:* The characteristic withdrawal syndrome for alcohol. Or alcohol (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms.	0	1
	(Alcohol Use Disorder) – Total		

Relationships

Where do you place your highest priorities? Rank the following in order of your priorities, with 1 representing your highest priority and 5 representing your lowest. (Do not use a number more than once)

___ Children ___ Peers & Other Family Members ___ God ___ Spouse/Significant Other ___ Self

From whom do you receive emotional support? (eg. comfort, compassion, concern, curiosity, empathy, joy, love, nurturance, respect, trust). Rate each item from 1 to 10 with 10 representing the greatest support, and 1 representing the least. (You may use any number more than once).

Patient Assessment Form – Mental Health

Name: ____ Date: __________________

___ Children ___ Peers ___ Other Family Members ___ God ___ Spouse/Significant Other

___ Self ___ Therapist

With whom do you have the most conflict? (eg. alienation, anger, anxiety, confusion, fear, grief-loss, guilt, hopelessness, shame). Rate each one from 1 to 10, with 10 representing the greatest conflict, and 1 representing the least. (You may use any number more than once).

___ Children ___ Peers ___ Other Family Members ___ God ___ Spouse/Significant Other

___ Self ___ Therapist

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